Department of Health & Human Services

Office of Inspector General

Cost-Saver Handbook

THE 1997-98

RED

BOOK

June Gibbs Brown
Inspector General

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

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Introduction to the Red Book

Purpose of the Red Book

The *Red Book* is a compendium of significant Office of Inspector General (OIG) cost-saving recommendations that have not been fully implemented. These recommendations may require one of three types of actions: legislative, regulatory, or other administrative (such as manual revisions). Some complex issues involve two or all three types of actions.

The Inspector General Act requires that the OIG's semiannual reports to the Congress include "an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed." Thus, appendices to each semiannual report list significant unimplemented recommendations. Because of the abbreviated nature of this list, however, we prepare the *Red Book* to further highlight the potentially significant impact of cost-saving recommendations.

The savings estimates indicated for these unimplemented recommendations are updated from time to time to reflect more current data as it becomes available. The estimates have varying levels of precision. Full implementation of the recommendations in this 1997-98 edition of the *Red Book* could produce substantial savings to the Department.

Department of Health and Human Services

The Department of Health and Human Services (HHS) promotes the health and welfare of Americans and provides essential services to people of every age group. Eighty-five percent of the HHS budget provides medical care coverage for the elderly, the disabled, and the poor. The balance of the programs support research into the causes of disease, promote preventive health measures, support the provision of health and social services, and combat alcoholism and drug abuse.

The Department's operating divisions are briefly described below:

- The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs.

- The Public Health Service (PHS) agencies include the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Agency for Toxic Substances and Disease Registry, the Agency for Health Care Policy and Research, and the Substance Abuse and Mental Health Services Administration. They promote biomedical research and

disease cure and prevention; ensure the safety and efficacy of marketed food, drugs, and medical devices; measure the impact of toxic waste sites on health; and conduct other activities designed to ensure the general health and safety of American citizens.

- The Administration for Children and Families (ACF) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families, including a variety of social service programs for American children and families, Native Americans, and the developmentally disabled.

- The Administration on Aging (AoA) serves as an advocate for older persons at the national level.

- General departmental management (GDM) includes such staff division activities as financial management and grant and contract administration.

Organization of the Red Book

The following sections of the *Red Book* separately address the OIG's recommendations to each of the operating divisions listed above. Most of these recommendations stem from final reports. Recommendations from draft reports represent the OIG's tentative position and are subject to change when the final versions of the reports are issued.

For each recommendation, we summarize the current law, the reason that action is needed, the estimated savings that would result from taking the recommended action, the status of actions taken, and the report number and date. In addition, the type of action needed (legislative, regulatory, or other administrative) is indicated. Recommendations for proposed legislation are removed from the *Red Book* once the law has been fully enacted. On regulatory and other administrative issues, recommendations are removed when the action has been substantially completed.

Each final report, including the full text of comments from the cognizant operating division, is available upon request. Each report also includes an appendix detailing OIG's methodology for estimating cost savings; we encourage the reader interested in a particular proposal to review the report.

The Red Book at a Glance

We hope that this 1997-98 edition of the *Red Book* will prove to be a useful asset for departmental decision-makers, the Administration, and the Congress in their continuing efforts to contain costs and improve program efficiency at HHS. A quick glance at OIG's cost-saving recommendations is provided on the following page.

The Red Book at a Glance

Red Book Items	HCFA	PHS Agencies	ACF	GDM	Total
Type of Action Recommended					
Legislative	34	2	2	2	40
Regulatory	7	0	0	0	7
Administrative	10	3	2	1	16
Estimated Savings by Type of Action (in millions of dollars)					
Legislative	$15,847	$186	$258	$896	$17,187
Regulatory	753	0	0	0	753
Administrative	459	35	21	22	537

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**** These estimated savings have varying levels of precision.***

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Public Health Service Agencies

**** These estimated savings have varying levels of precision.***

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**** These estimated savings have varying levels of precision.***

Table of Contents:
General Departmental Management

**** These estimated savings have varying levels of precision.***

HEALTH CARE FINANCING ADMINISTRATION

Health Care Financing Administration

Overview

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. Medicare Part A provides hospital and other institutional insurance for persons age 65 or older and for certain disabled persons, including those with end stage renal disease, and is financed by payroll tax deductions through the Federal Hospital Insurance Trust Fund. Medicare Part B (Supplementary Medical Insurance), which is financed by participants and general revenues, is an optional program which covers most of the costs of medically necessary physician and other services.

The Medicaid program provides grants to States for medical care for approximately 37 million low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for cash assistance programs. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average.

Significant OIG Activities

Over the years, Office of Inspector General (OIG) findings and recommendations have contributed to many significant reforms in the Medicare program. Such reforms include implementation of the prospective payment system for inpatient hospital services and a fee schedule for physician services; the Clinical Laboratory Improvement Amendments of 1988; regional consolidation of claims processing for durable medical equipment; and new payment methodologies for graduate medical education.

The unimplemented OIG recommendations in this *Red Book* that relate to HCFA activities could produce significant annual savings and recoveries to the Department. The OIG has identified a number of significant Medicare policy issues, such as revising prescription drug payment methods, adjusting graduate medical education costs, and reducing reimbursement for hospital capital costs. Regarding Medicaid, the OIG has recommended modifying the formula that determines the Federal share of costs, promoting Medicaid cost sharing, and controlling Medicaid payments to institutions for mentally retarded people.

REQUIRE MEDICARE COVERAGE OF ALL STATE AND LOCAL GOVERNMENT EMPLOYEES OR MAKE MEDICARE THE SECONDARY PAYER

Current Law:

The Consolidated Omnibus Budget Reconciliation Act of 1985 established Medicare Part A coverage and payment of hospital insurance contributions for new State and local government employees hired after March 31, 1986. However, employees hired before April 1, 1986, are not covered by Medicare Part A unless the government entity has voluntarily agreed to cover groups of its employees under the full Old-Age, Survivors and Disability Insurance program.

Proposal:

Medicare coverage and hospital insurance contributions should be required for all State and local employees, including those hired before April 1, 1986. If this proposal is not enacted, HCFA should seek legislation making Medicare the secondary payer for retirees from exempt State and local agencies.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Retirees from exempt agencies paid significantly lower taxes than nonexempt retirees. We estimate that over a 9-year period (1982-1990), Medicare will have spent about $16.9 billion in benefits for these retirees. However, only an estimated $2.7 billion of taxes, with interest, will have been collected, leaving a shortfall of $14.2 billion to be subsidized by other taxpayers. Most of these retirees qualify for Medicare through other covered employment or as a spouse of a covered worker. Those insured through other employment contributed far less for their coverage than other retirees, yet their hospital benefit protection is the same. Furthermore, exempt government agencies that did not pay the employer's share of hospital insurance contributions will have the windfall advantage of Medicare as the primary payer of health costs for retirees over age 65. Both conditions unfairly drain the hospital insurance trust fund and are inequitable to employees and employers who must contribute.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,559	$1,552	$1,521	$1,490	$1,451

Status:

Although HCFA included a proposal to mandate Medicare coverage for all State and local government employees in the FY 1990 budget submission, no legislative proposal was included in the President's current budget. Also, HCFA did not agree with our recommendation to make Medicare the secondary payer, noting, among other things, that this would eventually be more costly for the exempt agencies than mandated coverage.

Report:

A-09-88-00072 (Final report, Feb. 1989)

CONTINUE MANDATED REDUCTIONS IN HOSPITAL CAPITAL COSTS

Current Law:

On October 1, 1991, HCFA began a 10-year transition period for paying hospital capital costs under a prospective payment system. Final regulations were promulgated August 30, 1991 (56FR43358). The rates are based on historical costs, less a mandated reduction of 7.4 percent under the Omnibus Budget Reconciliation Act of 1993.

Proposal:

The HCFA should (1) seek legislative authority to continue mandated reductions in capital payments beyond FY 1995 and (2) determine the extent that capital payment reductions are needed to fully account for hospitals' excess bed capacity and report the percentage of reduction to the Congress.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Hospital capital costs soared during the first 5 years of the prospective payment system (PPS), despite low bed occupancy. The Medicare system of reimbursing capital costs on a pass-through basis (i.e., reimbursed outside of diagnosis related group) was a major reason for this increase. Paying capital costs prospectively, as required by recently implemented regulations, should assist in curbing escalating costs. However, the PPS rates are based on historical costs that are inflated because (1) excess capacity in the hospital industry has caused more capital costs to be incurred than economically necessary and (2) inappropriate elements, such as charges for depreciation on federally funded assets, are included in the historical costs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$820	$950	$1140	$1450	$1840

Status:

The HCFA did not agree with our recommendation. Although the Balanced Budget Act of 1997 reduces capital payments, it does not include the effect of excess bed capacity and other elements included in the base year historical costs.

Report:

A-09-91-00070 (Final report, Apr. 1992)
A-14-93-00380 (Final report, Apr. 1993)

MORE ACCURATELY REFLECT BASE YEAR COSTS IN PROSPECTIVE PAYMENT SYSTEM'S CAPITAL COST RATES

Current Law:

Under section 1886(d) of the Social Security Act, the Medicare program pays for the operating costs attributable to hospital inpatient services under a prospective payment system (PPS). A PPS pays for care using a predetermined specific rate for each discharge. Public Law 100-203 required the Secretary of Health and Human Services to establish a PPS for capital costs for cost reporting periods beginning in FY 1992.

Proposal:

The HCFA should (1) consider reducing payment rates by 7.5 percent to more accurately reflect costs of the base year used for the capital cost PPS and (2) continue to monitor the most current data and make any necessary further adjustments to the base rate.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

While HCFA took great pains to devise and implement an equitable PPS for capital costs, information now available indicates that HCFA's 1992 estimated base year rate is 7.5 percent higher than current actual costs. A 7.5 percent reduction would also correct all forecasting estimates that HCFA had to make in arriving at an anticipated rate to implement the capital cost PPS. The total effect of overpayments in relation to cost used as the basis for the capital cost PPS will gradually increase from 1996 until the capital cost PPS is fully implemented in 2002.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$249	$284	$319	$354	$388

Status:

The HCFA agreed that the capital rate reflected an overestimation of base year costs, and the Balanced Budget Act of 1997 provides for a reduction in capital payments for 1998-2002. However, we believe HCFA should continue to monitor current data since additional reductions may be warranted in the future.

Report:

A-07-95-01127 (Final report, Aug. 1995)

REDUCE THE PROSPECTIVE PAYMENT SYSTEM ADJUSTMENT FACTOR FOR INDIRECT MEDICAL EDUCATION COSTS

Current Law:

Since the inception of Medicare's prospective payment system (PPS), indirect medical education payments have been paid only to teaching hospitals. These payments are designed to alleviate an anticipated adverse effect that PPS would have on teaching hospitals. The indirect medical education adjustment factor was determined by HCFA and the Congress. Using historical data, HCFA compared costs per case in teaching and nonteaching hospitals using regression analysis and determined that operating costs in hospitals with teaching programs increased approximately 5.79 percent for every 0.1 resident physician per hospital bed compared with hospitals without teaching programs. Under a congressional mandate, HCFA was required to double the adjustment factor under PPS--increasing it to 11.59 percent.

The Consolidated Omnibus Budget Reconciliation Act of 1985 reduced the indirect medical education adjustment factor from 11.59 percent to 8.1 percent for discharges occurring on or after May 1, 1986, and before October 1, 1988. The Omnibus Budget Reconciliation Act of 1987 further modified the adjustment by reducing it to approximately 7.7 percent for each 0.1 in the ratio of interns and residents to beds.

Proposal:

The indirect medical education adjustment factor should be reduced to the level supported by HCFA's empirical data, and further studies should be made to determine whether different adjustment factors are warranted for different types of teaching hospitals.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our extensive analytical work shows that teaching hospitals continue to earn substantial profits. In addition, a Prospective Payment Assessment Commission report found that the indirect medical education adjustment substantially overlaps with the disproportionate share adjustment at teaching hospitals and that these payments are a major source of revenue for some hospitals.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA agreed with our recommendation. In addition, the Balanced Budget Act of 1997 gradually reduces the indirect medical education adjustment factor from the current 7.7 percent in FY 1997 to 5.5 percent in 2001 and thereafter. We believe the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.

Report:

A-07-88-00111 (Final report, Sept. 1989)

REVISE GRADUATE MEDICAL EDUCATION PAYMENT METHODOLOGY

Current Law:

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and section 9314 of the Omnibus Budget Reconciliation Act of 1986 changed the way Medicare reimburses hospitals for the cost of direct graduate medical education. Under the new methodology, these costs are reimbursed on a "hospital specific" prospective payment basis, which is retroactive to cost reporting periods beginning on or after July 1, 1985.

Proposal:

The HCFA should (1) revise the regulations to remove from a hospital's allowable graduate medical education base year costs any cost center with little or no Medicare utilization and (2) submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system.

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

The HCFA estimated that the new graduate medical education regulations would result in substantial Medicare savings. Our review indicated that Medicare costs under the new reimbursement method may actually increase because of two factors. First, the new system allows hospital cost centers with little or no Medicare patient utilization to receive increased importance in the calculation of the graduate medical education reimbursement. Second, the Medicare patient load percentage used in the new system to compute Medicare's share of these costs is based on inpatient data only and is higher than Medicare's overall share of graduate medical education costs as determined under the previous method, which also included ancillary and outpatient data.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Factor 1	$ 39.2	$ 39.2	$ 39.2	$ 39.2	$ 39.2
Factor 2	125.6	125.6	125.6	125.6	125.6
Combined *	157.3	157.3	157.3	157.3	157.3

** Note: When the two proposed changes are handled as one combined calculation, the savings are less than those from calculating the effect of the changes separately.*

Status:

The HCFA did not concur with our recommendations. Although the Balanced Budget Act of 1997 contains provisions to slow the growth in Medicare spending on graduate medical education, we continue to believe that our recommendations should be implemented and that further savings can be achieved.

Report:

A-06-92-00020 (Final report, Apr. 1994)

DENY MEDICARE REIMBURSEMENT FOR PATIENTS WHO RECEIVE SUBSTANDARD MEDICAL CARE

Current Law:

Under Medicare, hospitals receive a pre-established payment for each discharge based on an assigned diagnosis related group (DRG). Each DRG results in an associated payment that represents an average cost for patients having similar diagnoses. The Congress established peer review organizations to protect the integrity of the prospective payment system and to maintain the quality of care. The Consolidated Omnibus Budget Reconciliation Act of 1985 authorized these organizations to deny Medicare reimbursement for patients receiving substandard medical care, defined as medical care clearly failing to meet professionally recognized standards.

Proposal:

The HCFA should increase efforts to identify and address poor quality care in hospitals by issuing regulations to implement the provisions of the 1985 act.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

Of the patients sampled, 6.6 percent received poor quality of care.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$110	$110	$110	$110	$110

Status:

In 1989, HCFA issued a notice of proposed rulemaking to authorize the peer review organizations to deny Medicare reimbursement for patients who received substandard medical care. The HCFA has not yet issued a final regulation.

Report:

OEI-09-88-00870 (Final report, July 1989)

MODIFY PAYMENT POLICY FOR MEDICARE BAD DEBTS

Current Law:

Under Medicare's prospective payment system (PPS), hospitals are reimbursed for inpatient services rendered to Medicare beneficiaries by a fixed payment amount based on a diagnosis related group (DRG). However, bad debts related to unpaid deductible and coinsurance amounts are reimbursed separately as pass-through (i.e., reimbursed outside of DRG) items under reasonable cost principles.

Proposal:

We presented an analysis of four options for HCFA to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals which are profitable, and the inclusion of a bad debt factor in the DRG rates. The HCFA should seek legislative authority to further modify bad debt policies.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our review of HCFA's Hospital Cost Report Information System showed that total Medicare bad debts increased from $159 million during the second year of PPS (FY 1985) to $398 million during the fifth year of PPS (FY 1988). During this same period, hospitals continued to earn significant profits. Also, hospital bad debt collection efforts have often been less than adequate since there is little incentive for a hospital to collect the unpaid deductible and coinsurance amounts when Medicare pays these amounts.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

Agreeing with our recommendation to include a bad debt factor in the DRG rates, HCFA said that our report should assist the Congress in understanding the rapid growth in hospital bad debts. The Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers, but additional legislative changes are needed to implement the modifications we recommended.

Report:

A-14-90-00339 (Final report, June 1990)

LIMIT PROSPECTIVE PAYMENT SYSTEM REIMBURSEMENT FOR HOSPITAL ADMISSIONS NOT REQUIRING AN OVERNIGHT STAY

Current Law:

Under the prospective payment system (PPS), hospitals are reimbursed for each admission when the patient is discharged based on established rates which are grouped into diagnosis related groups (DRG). Current Medicare instructions provide that an admission occurs when it is expected that the patient will occupy a bed and remain overnight. This applies even if the person is later discharged or transferred to another hospital without actually using a hospital bed overnight.

Proposal:

The HCFA should seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Based on Medicare records for 1989, our follow-up review (A-05-92-00006) revealed that the volume of 1-day admissions on a national basis had increased approximately 150 percent over 1985 levels and that Medicare had paid for 179,500 admissions that did not require overnight stays. Many of these cases related to observations after emergency or outpatient services, to surgeries later canceled, or to acute care stays of doubtful necessity. In many cases, documentation revealed that few, if any, services were provided while the patient was an inpatient.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$210	$210	$210	$210	$210

Status:

The HCFA proposed to implement our recommendation through administrative remedies which would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.

Report:

A-05-89-00055 (Final report, July 1989)
A-05-92-00006 (Final report, Jan. 1992)

RECOVER OVERPAYMENTS AND EXPAND THE DIAGNOSIS RELATED GROUP PAYMENT WINDOW

Current Law:

Under the prospective payment system (PPS), Medicare fiscal intermediaries reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). Currently, separate payments for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission are not permitted under the Omnibus Budget Reconciliation Act of 1990, section 4003.

Proposal:

The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our review identified about $83.5 million in admission-related nonphysician outpatient services rendered 4 to 7 days immediately before an inpatient admission. The fiscal intermediaries cited clerical errors and insufficient or nonexistent edits for improper payments, and the hospitals cited clerical errors and misinterpretation of the regulations.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$83.5	$83.5	$83.5	$83.5	$83.5

Status:

The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and the OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.

Report:

A-01-92-00521 (Final report, July 1994)

REDUCE MEDICARE PAYMENTS FOR HOSPITAL OUTPATIENT SERVICES

Current Law:

To bring payments for services in hospital outpatient departments more in line with the payments for services in an ambulatory service center, the Omnibus Budget Reconciliation Act of 1990, section 4151, reduced Medicare payments for hospital outpatient services by (1) adjusting the payment formula to 58 percent of the ambulatory service center rates and 42 percent of the hospital's outpatient costs and (2) lowering hospital payments made on a reasonable cost basis by 5.8 percent. The Omnibus Budget Reconciliation Act of 1993 extended the 5.8 percent reduction in payments for hospital outpatient department services from FY 1996 through 1998.

Proposal:

Legislation is needed to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center approved payments. We recommended paying outpatient departments the ambulatory service center approved rate or adjusting hospital payments by a uniform percentage.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our study of hospital outpatient surgeries showed that the current blended rate to hospitals in the aggregate is greater than the payment rate for ambulatory service center approved services. We analyzed over 2 million hospital outpatient bills containing ambulatory center approved surgeries from 5,421 hospitals. The disparity between Medicare payments to outpatient departments and the centers for similar services still exists.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90	$107	$126	$147	$175

Status:

The HCFA acknowledged that our report would be helpful in developing a legislative proposal to bring about greater parity of payments for services performed in an outpatient setting and those performed in ambulatory service centers. Included in the Balanced Budget Act of 1997 is the requirement to develop a prospective payment system (PPS) for hospital outpatient services for FY 1999. The Act also includes provisions to eliminate a formula-driven overpayment which allows Medicare to fully deduct beneficiary coinsurance payments received by the hospital before the program makes its payments. We will monitor the implementation of the outpatient PPS to ensure that payment rates are comparable to the ambulatory service center rates.

Report:

A-14-89-00221 (Final report, Mar. 1991)
OEI-09-88-01003 (Final report, May 1989)

APPLY 190-DAY LIFETIME LIMIT FOR MEDICARE INPATIENT PSYCHIATRIC CARE AND A 60-DAY ANNUAL LIMIT

Current Law:

Medicare limits inpatient care in psychiatric hospitals to 190 days during a beneficiary's lifetime. When Medicare was passed, inpatient psychiatric care was rendered, for the most part, in State psychiatric hospitals. The Congress apparently believed that long-term care of the mentally ill was generally a State responsibility. The delivery of inpatient psychiatric care has expanded beyond the psychiatric hospitals to general hospitals with distinct psychiatric units. The 190-day limit was not extended to these more costly general hospital units.

Proposal:

The HCFA should develop new limits to deal with the high cost and changing patterns of utilization of inpatient psychiatric services. A 60-day annual and a 190-day lifetime limit should be applied to all psychiatric care regardless of the place of service.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The Medicare lifetime limit on psychiatric hospital care is no longer effective because of changed patterns of inpatient psychiatric care. Over 82 percent of the $1.36 billion in program payments for inpatient psychiatric care is being paid to general hospitals--where the lifetime limit does not apply. An annual limit on care, which has congressional precedence in a Department of Defense health care program, may be more acceptable than a lifetime limit. We believe a 60-day annual limit on inpatient psychiatric services will produce significant savings over the current uneven application of the Medicare lifetime limit.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47.6	$47.6	$47.6	$47.6	$47.6

Status:

The HCFA considered a proposal recommending that the 190-day lifetime limit for psychiatric admissions be extended to general hospitals. However, such a proposal was not included as part of the President's current budget.

Report:

A-06-86-62045 (Final report, Feb. 1988)

PRECLUDE IMPROPER PAYMENTS TO HOSPITALS FOR HOSPICE BENEFICIARIES

Current Law:

When a beneficiary elects hospice care, the Medicare program reimburses the hospice a fixed rate for each day of care. The hospice then assumes fiscal responsibility for all Medicare Part A services related to the beneficiary's terminal illness. A separate Medicare payment to the hospital is not allowable; instead the hospital should bill the hospice, and the hospice then receives a higher daily rate for the number of days the hospice beneficiary is hospitalized.

Proposal:

The HCFA should instruct its fiscal intermediaries to recover improper payments from hospitals noted in our review and to review related medical records for the potential inappropriate payments we identified.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Our review showed that over $21 million in overpayments should be recovered for Calendar Years 1988-1992. In addition, more effective edits of hospital/hospice claims could result in annual savings of approximately $4 million over the next 5 years.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$4	$4	$4	$4	$4

Status:

The HCFA agreed to recover the overpayments identified and to instruct its fiscal intermediaries to review the claims we identified as potential overpayments. We are currently doing additional work to assess the effectiveness of HCFA's common working file edits in regard to hospice/hospital payments.

Report:

A-02-93-01029 (Final report, June 1995)

SELECTIVELY CONTRACT FOR CORONARY ARTERY BYPASS GRAFT SURGERY

Current Law:

Medicare pays for coronary artery bypass graft surgery costs incurred for physician, hospital, and other services. Payment for hospitals is based on diagnosis related group (DRG) rates, and payment for physician and other services is based on reasonable charge determinations.

Proposal:

The HCFA should negotiate all-inclusive package payment prices with selected surgeons and medical centers for providing coronary artery bypass graft surgery to Medicare beneficiaries.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

In 1985, Medicare payments for coronary artery bypass graft surgery (DRG codes 106 and 107) totaled over $1.5 billion--an amount that has increased over the years. Hospitals and surgical teams performing more than 200 of these surgeries per year had better outcomes, in terms of mortality rates, lengths of stay, and charges, than those performing fewer surgeries. The reasonable charge allowances for physicians are often inconsistent and inequitable. Similarly, both inconsistent carrier controls/payment guidelines and the revised HCFA procedure coding system have increased Medicare costs for this surgery. Current legislation does not allow the negotiation of preferred provider and fixed-price packages for bypass surgery for Medicare patients, despite the fact that these practices save the private sector millions of dollars each year.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$543.9	$543.9	$543.9	$543.9	$543.9

Status:

The HCFA conducted a demonstration project which ended in July 1996. The demonstration alone saved $300 million. A final report will be issued in March 1998.

Report:

OEI-09-89-00076 (Final report, Aug. 1987)

ROLL REIMBURSEMENT FOR LABORATORY SERVICES INTO CHARGE FOR PHYSICIAN OFFICE VISITS

Current Law:

Medicare pays the full amount of all clinical laboratory services provided in outpatient and office settings based on fee schedules.

Proposal:

The HCFA should propose legislation to roll the reimbursement for laboratory services into the recognized charge for physician office visits (which are subject to beneficiary co-payment).

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Clinical laboratory claims account for 25 percent of the line items in Medicare bills. Numerous initiatives to limit inappropriate growth have been enacted into law in recent years. Most involve limiting the amount paid for each laboratory service. These initiatives have failed to limit overall spending, however, because they did not reduce the number of tests prescribed. Our proposal would eliminate incentives for inappropriate lab tests while still allowing sufficient funds to pay for needed services; unnecessary tests would decrease as a result of the incentive to control costs; beneficiary coinsurance and deductible provisions would again come into play; and administrative savings would result from the reduction in the number of claims processed.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Roll-in	$ 700	$1,500	$2,700	$4,100	$6,000
Co-payment	1,130	1,240	1,370	1,520	1,690
Admin. savings	210	210	210	210	210
Total	$2,040	$2,950	$4,280	$5,830	$7,900

Status:

The HCFA does not concur with our recommendation but is studying alternative ways to limit laboratory services. We plan to conduct additional analytical work related to this topic.

Report:

OEI-05-89-89150 (Monograph, Oct. 1990)
OEI-05-89-89151 (Management advisory report, July 1991)

EXPAND NATIONAL LIST OF CHEMISTRY PANEL TESTS

Current Law:

Chemistry tests are clinical laboratory services requested by physicians in order to diagnose and treat patients. Chemistry tests that are commonly performed on automated laboratory equipment are referred to as panel tests and are required by HCFA to be grouped together for payment purposes. In addition, HCFA requires that other chemistry tests available in a carrier's service area and commonly performed on automated laboratory equipment be reimbursed as panel tests.

Proposal:

The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by our audit.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Based on claims information and responses to questionnaires by hospital and independent laboratories related to 18 tests identified for review, 10 are available in all carrier service areas and are commonly performed on automated equipment. These 10 tests should be paid as panel tests. However, HCFA's guidelines specifying chemistry tests that should be paneled by all carriers have not been updated promptly to add tests as technology has advanced.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$130	$130	$130	$130	$130

Status:

The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 3 of these tests to its carrier manual in November 1995. A legislative proposal to add tests was not included in the President's current budget.

Report:

A-01-93-00521 (Final report, Jan. 1995)

ENCOURAGE PHYSICIANS TO USE PAPERLESS CLAIMS

Current Law:

Physicians may submit claims to Medicare in either paper or electronic form. Seventy-three percent of all physician claims are currently submitted electronically, and 59 percent of Medicare physicians use only paper.

Proposal:

The HCFA should:

- Lead a target outreach effort to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch.

- Begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claims submission will become a condition for Medicare participating physician status, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Approximately 65 percent of physicians who now submit Medicare claims only on paper indicate a high or moderate level of interest in switching to paperless claims.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$126	$126	$126	$126	$126

Status:

The HCFA concurred with our recommendations and is developing a corrective action plan.

Report:

OEI-01-94-00230 (Final report, May 1996)
A-05-94-00039 (Final report, May 1996)

MODIFY MEDICARE INCENTIVE PAYMENTS IN HEALTH PROFESSIONAL SHORTAGE AREAS

Current Law:

Since 1989, physicians who treat Medicare patients in HHS-defined health professional shortage areas have been entitled to bonus payments that were designed to improve patient access to care. The current law calls for a 10 percent bonus.

Proposal:

The HCFA should seek to (1) eliminate the Medicare incentive payments entirely, (2) modify the Medicare incentive payment program to target it more effectively to primary care, or (3) channel funds from the Medicare incentive payment program to new or existing mechanisms for improving access to primary care.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

A substantial amount of the Medicare incentive money has gone to physicians who provide little or no primary care. Also, among primary care physicians, Medicare incentive payments apparently have little effect on practice location decisions.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90.6	$120.8	$161	$214.6	$286

Status:

The HCFA concurred with our recommendation and had previously advanced legislation to provide larger bonuses for primary care services and to eliminate certain bonuses in urban areas. However, this proposal was not included in the President's current budget, and HCFA has no immediate plans to pursue legislation for this initiative. The U.S. General Accounting Office recently made a recommendation similar to ours based on its review of definitions of health professional shortage areas.

Report:

OEI-01-93-00050 (Final report, June 1994)

REDUCE MEDICARE END STAGE RENAL DISEASE PAYMENT RATES

Current Law:

The Omnibus Budget Reconciliation Act of 1981 established a prospective payment system for outpatient dialysis treatments under Medicare's end stage renal disease (ESRD) program. To reimburse facilities for these treatments, HCFA pays a composite rate per treatment based on audited median costs. In FY 1989, payments averaged $125.05 per treatment for freestanding facilities and $129.11 for hospitals.

Proposal:

The HCFA should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The HCFA, with our assistance, accumulated 1985 and 1988 cost data to update the composite rates. The 1985 data showed a median cost, including home dialysis costs, of $108.19 per treatment. Even after considering the effect of home dialysis services, the in-facility costs decreased from 1980 to 1985 without a corresponding reduction in the prospective rates. In addition, our audit of the 1988 home office costs of a major chain of freestanding facilities showed that its costs decreased from $117 per treatment in 1980 to $89 in 1988. Due to the prominence of this chain, these audited costs have a significant impact on the median cost of dialysis treatments. We estimated that this chain is earning $36 per treatment, a 29 percent profit margin for each treatment in 1988. We believe that both the 1985 and 1988 audited data justify a decrease in the payment rate.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$22*	$22*	$22*	$22*	$22*

**This savings estimate represents program savings of $22 million for each dollar reduction in the composite rate.*

Status:

The HCFA agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing these rates, it mandated a study to determine the costs, services, and profits associated with various modalities of dialysis treatments. A March 1996 study by the Prospective Payment Assessment Commission recommended an increase in the current rates, but HCFA did not believe an across-the-board increase was warranted. HCFA officials said they would continue to monitor facilities' costs and other factors (including volume, effects of a new wage index, quality of care, and industry growth and profitability) to determine if a payment rate increase would be appropriate. Toward this end, the Balanced Budget Act of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The HCFA does not believe that these audits will produce a recommendation to decrease composite payment rates and estimates that the audits may reduce the average facilities' costs by less than 5 percent.

Report:

A-14-90-00215 (Final management advisory report, July 1990)

ENSURE THAT CLAIMS FOR AMBULANCE SERVICES FOR END STAGE RENAL DISEASE BENEFICIARIES MEET COVERAGE GUIDELINES

Current Law:

The Medicare Part B benefit for ambulance service has very strict limits, as explained by HCFA in the Medicare Carriers Manual, section 2120. The transport is not covered if it fails to meet the medical necessity requirement, even if it meets other requirements.

Proposal:

The HCFA should ensure that claims meet Medicare coverage guidelines.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

Seventy percent of transports involving dialysis in our sample did not meet Medicare's guidelines for medical necessity because beneficiaries did not have conditions that contraindicated use of another type of transport. Almost two-thirds of the beneficiaries were clearly not bed-confined.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90	$99	$100	$101	$102

Status:

The HCFA issued a notice of proposed rulemaking in June 1997 which addressed Medicare ambulance payment issues. This regulation contained a provision to require physician certification of nonemergency transports. However, the regulation has not been issued in final.

Report:

OEI-03-90-02130 (Final report, Aug. 1994)

MODIFY PAYMENT PRACTICES OF AMBULANCE SERVICES FOR MEDICARE END STAGE RENAL DISEASE BENEFICIARIES

Current Law:

Medicare Part B covers ambulance services under certain conditions; it prohibits coverage for ambulance transportation unless the beneficiary is normally bed-confined and must be transported by stretcher. Ambulance company services and charges are represented by alphanumeric codes which the Medicare program uses to analyze utilization and payments. Persons with ESRD are entitled to Medicare coverage under the 1972 amendments to the Social Security Act.

Proposal:

The HCFA should ensure appropriate payment for services rendered and may consider using one or more of the following strategies: (1) establish a payment schedule for ambulance transport to maintenance dialysis, and set the fee lower than that paid for unscheduled, emergency transports; (2) negotiate preferred provider agreements with ambulance companies to provide scheduled transportation for ESRD beneficiaries; (3) use competitive bidding to establish a price for scheduled transports for ESRD beneficiaries or to select companies that agree to provide such services; (4) establish a rebate program for companies that routinely transport ESRD beneficiaries; and (5) provide an add-on to the composite rate Medicare pays dialysis facilities, and allow the facilities to negotiate agreements with ambulance companies.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

The payment system does not take into account the routine, predictable nature of scheduled ambulance transports, nor does it take advantage of the lower costs associated with high-volume scheduled transports.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Lower estimate $4.9	$6.0	$7.3	$8.9	$10.9	
Upper estimate 14.7	18.0	22.0	26.8	32.7	

Status:

The HCFA has established codes for scheduled transport and has required uniform use of national ambulance codes but has not modified the payment method. The Balanced Budget Act of 1997 authorizes the establishment of a prospective payment system which links payments to the type of services provided, effective January 1, 2000.

Report:

OEI-03-90-02131 (Final report, Mar. 1994)

COLLECT OVERPAYMENTS FROM HEALTH MAINTENANCE ORGANIZATIONS FOR MISCLASSIFIED END STAGE RENAL DISEASE BENEFICIARIES

Current Law:

Health maintenance organizations (HMOs) receive a monthly list of Medicare beneficiaries who have been classified as having end stage renal disease (ESRD). Monthly payment rates to HMOs for these beneficiaries are about 7 to 10 times higher than the rates for other Medicare beneficiaries. There are no statutory, regulatory, or manual provisions which specify time limits for the recovery of overpayments from risk-based HMOs. In contrast, Medicare's fee-for-service program imposes a 3-year statute of limitations on overpayment collections.

Proposal:

The HCFA should issue clear guidelines for the recovery of overpayments from HMOs. Also, HCFA should recover all overpayments occurring at least since 1992 which were made to HMOs on behalf of misclassified ESRD beneficiaries.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Because of weaknesses in HCFA's systems, some beneficiaries were misclassified as having ESRD. The HMOs knew, or should have known, that the misclassified beneficiaries were not receiving ESRD services which they were being paid to provide. It would be logical to collect the overpayments from HMOs on the same basis as overpayments are collected from providers in the Medicare fee-for-service program, that is, for up to 3 years. Since plans were formally notified in February 1995 of HCFA system weaknesses and the resulting overpayments, we believe collections should be made retroactively to 1992.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$20.5				

Status:

The HCFA agreed to clarify its policies for collecting overpayments from HMOs. However, it collected overpayments retroactively only to March 1995 for the majority of misclassified beneficiaries and retroactively to October 1993 for the remaining beneficiaries who were misclassified as having ESRD before enrollment in the HMO. Due to this limited recovery schedule, HCFA has not collected $20.5 million in overpayments which occurred since 1992. The HCFA disagreed with our recommendation to collect the overpayments retroactively to 1992.

Report:

A-14-96-00203 (Final report, June 1997)

ENSURE LEGITIMACY OF MEDICARE SUPPLIERS

Current Law:

Before businesses can bill Medicare for the sale and rental of durable medical equipment, they must apply for and receive a supplier number. To help ensure that applicants are bona fide businesses, HCFA also requires that each supplier meet 11 standards.

Proposal:

The HCFA should charge all applicants an application fee to cover all costs associated with processing applications, including the costs of conducting on-site visits at applicants' physical locations.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

We found that 1 of every 14 suppliers and 1 of every 9 new applicants did not have a required physical address. Further, 41 percent of suppliers and 40 percent of new applicants failed to meet at least one supplier standard.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA concurred with our recommendation and is actively increasing the areas in which it conducts site visits of applicants. In addition, the Balanced Budget Act of 1997 contained a number of reforms, including requiring a surety bond for durable medical equipment suppliers.

Report:

OEI-04-96-00240 (Draft report, Apr. 1997)

LIMIT MEDICARE PART B REIMBURSEMENT FOR HOSPITAL BEDS

Current Law:

Medicare Part B allows for reimbursing suppliers of hospital beds used at home by Medicare beneficiaries if the beds are prescribed by physicians. Monthly rental payments are made according to a fee schedule established by the Omnibus Budget Reconciliation Act of 1987. Medicare payments are capped at 120 percent of the allowed fee schedule amount over a maximum 15-month period.

Proposal:

The HCFA should develop a new approach for reimbursing suppliers of hospital beds used by Medicare beneficiaries at home. The new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our sample of beneficiaries in Texas during 1989 disclosed that the current Medicare reimbursement policy allows a bed supplier to recover the bed's wholesale cost within approximately 4 months. The majority of rentals in our sample were for periods of less than 6 months. Since the useful life of a hospital bed is 5 years, we estimated that a supplier could recover the wholesale cost of a bed as many as 7.5 times over the life of the bed.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$6.2	$6.2	$6.2	$6.2	$6.2

Status:

The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least 3 sites for 2 cycles of 2 years each beginning in January 1997. The Balanced Budget Act of 1997 requires the Secretary to conduct a competition among individuals and entities supplying Part B items and services. However, only oxygen and oxygen equipment were specifically mentioned for one of the five demonstration projects.

Report:

A-06-91-00080 (Final report, May 1993)

REDUCE PAYMENTS FOR PRESSURE SUPPORT SURFACES

Current Law:

Federal law states that durable medical equipment provided in the beneficiary's residence may be billed only to Medicare Part B. This equipment includes pressure-reducing support surfaces used for the care of decubitus ulcers or pressure sores. The HCFA processes equipment claims through four regional carriers called durable medical equipment regional carriers. Effective January 1, 1996, new regional carrier guidelines were developed to control medically unnecessary Medicare reimbursement for support surfaces.

Proposal:

The HCFA should require periodic review and renewal of the certificate of medical necessity for beneficiaries' use of group 2 support surface equipment.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

While the 1996 guidelines appear to be having a positive impact on controlling Medicare costs for support surfaces, inappropriate payments are still noted. In 1996, 29 percent of beneficiaries sampled used support surfaces that were medically unnecessary, compared with 47 percent in 1995.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$12	$12	$12	$12	$12

Status:

The HCFA did not agree with our recommendation and expressed concern about the timeliness and costs associated with using a certificate of medical necessity for group 2 equipment.

Report:

OEI-02-95-00370 (Final report, June 1997)

IMPROVE BILLING PRACTICES FOR MEDICARE ORTHOTICS

Current Law:

Section 1834(h) of the Social Security Act provides for payment of orthotics and prosthetics as described in section 1861(s)(9). The HCFA regulations define "orthotic devices" as leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements if required because of a change in the beneficiary's physical condition. Orthotic devices, which are mainly covered under Medicare Part B, must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve a malformed body member.

Proposal:

The HCFA, in concert with the durable medical equipment regional carriers, should:

- Develop guidelines that better define orthotic devices, distinguishing among such categories of devices as custom-made and off-the-shelf;
- Develop policies for orthotic codes, giving priority to upper limb devices, which we have identified as most problematic;
- Develop screens for billing many orthotic devices on the same day or within a short time frame and pay special attention to billing for orthotics in nursing facilities;
- Work with the American Orthotic and Prosthetic Association to develop a table of devices that should not be used together; and
- Consider stricter standards for who is allowed to bill for orthotics, such as requiring professional credentials for orthotic suppliers.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

The OIG's medical record review, performed in concert with the Medicare peer review organizations, found that at least 19 percent of the orthotic devices covered in our study were medically unnecessary. Also, 68 percent of the orthotic billings for patients in nursing facilities were questionable, and the medical equipment carriers have no policy for the majority of the orthotic billing codes.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$7.9	$7.9	$7.9	$7.9	$7.9

Status:

The HCFA concurred with our recommendations and has revised its national codes to distinguish among categories of devices.

Report:

OEI-02-95-00380 (Final report, Oct. 1997)

EXAMINE PAYMENT METHOD FOR PARENTERAL NUTRITION

Current Law:

Parenteral nutrition, a liquid solution provided intravenously through use of an indwelling catheter and infusion pump, is covered under Medicare's Part B prosthetic device provision. Medicare uses the reasonable charge methodology to determine allowances for 23 parenteral nutrition procedure codes.

Proposal:

The HCFA should examine other payment methods that could lead to more cost-effective reimbursement for parenteral nutrition solutions. We suggest three alternative payment methods: (1) inherent reasonableness, (2) acquisition cost, and (3) competitive bidding.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

For four parenteral nutrition codes, Medicare pays an average of 45 percent more than Medicaid agencies and 78 percent more than Medicare risk health maintenance organizations (HMOs).

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$65	$65	$65	$65	$65

Status:

The Balanced Budget Act of 1997 enacted several provisions that would address our recommendation. Section 4316 authorizes HCFA to make "inherent reasonableness" adjustments up to 15 percent for all Part B services other than physician services. Also, section 4319 authorizes up to five competitive bidding demonstrations. The HCFA has convened a workgroup to focus on ways to reduce costs for parenteral nutrition.

Report:

OEI-03-96-00230 (Final report, July 1997)

REDUCE AND CONTROL ENTERAL NUTRITION EQUIPMENT COSTS

Current Law:

Enteral nutrition therapy, commonly called tube feeding, provides nourishment to patients who cannot swallow because of severe or permanent medical problems. This therapy, covered under Medicare Part B as a prosthetic benefit, is limited to patients unable to eat normally who require enteral therapy as their primary source of nutrition. The durable medical equipment regional carriers were created by Federal regulation in 1993 to establish medical policy and guidelines for the review of durable medical equipment claims.

Proposal:

The durable medical equipment regional carriers should consider selecting claims for special formulas, pump equipment, and/or pump supply kits when they determine target areas for focused medical reviews.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Eighty percent of the beneficiaries sampled met Medicare criteria for enteral nutrition therapy in 1995. However, vulnerabilities were identified with the use of special enteral formulas and the pump delivery method.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$28	$28	$28	$28	$28

Status:

The HCFA agreed with our recommendation. Also, the Balanced Budget Act of 1997 contained several reforms related to reimbursement for beneficiaries in nursing homes, including a mandatory prospective payment system for Part A covered stays and consolidated billing for beneficiaries not in Part A covered stays.

Report:

OEI-03-94-00022 (Draft report, Mar. 1997)

REDUCE MEDICARE PART B PAYMENTS FOR ENTERAL NUTRITION AT HOME

Current Law:

Enteral nutrition therapy is covered under Medicare Part B as a prosthetic benefit, limited to patients unable to eat normally who require enteral therapy as their primary source of nutrition. While the majority of payments are for patients in nursing homes, some patients receive enteral therapy as part of home care.

Proposal:

The HCFA should reduce payments through competitive acquisition strategies for patients receiving enteral nutrition at home.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Payments for enteral nutrition therapy are excessive because reimbursement rates are high and competitive acquisition strategies are not fully used. In our review of other payers of enteral nutrition, we found that payers who negotiated prices, taking advantage of discounts and other competitive acquisition strategies, reimbursed from 17 to 48 percent less than Medicare.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Enteral payments for non-nursing-home residents	$15	$15	$ 15	$ 15	$ 15

The savings is based on a 17 percent savings through use of competitive acquisition strategies applied to 34 percent (non-nursing-home residents) of the total enteral nutrient expenditure of $330 million in 1994.

Status:

The HCFA concurs that Medicare is paying too much for enteral nutrients and supports the recommendation to reduce payments for enteral therapy administered at home under Part B. Included in section 4552(a) of the Balanced Budget Act of 1997 is a provision to freeze Medicare payments for parenteral and enteral nutrition, equipment, and supplies for 1998 through 2002. However, we believe additional reductions are appropriate.

Report:

OEI-03-94-00021 (Final report, Apr. 1996)

ELIMINATE SEPARATE ENTERAL NUTRIENT PAYMENTS IN NURSING HOMES

Current Law:

Suppliers may bill Medicare Part B for enteral nutrients delivered to patients in nursing homes or may furnish such services under arrangements with nursing homes in which the nursing home claims the cost of the service.

Proposal:

The HCFA should eliminate separate payments for enteral nutrients for beneficiaries in nursing homes.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Medicare allowed $218 million for enteral nutrition in 1994 for beneficiaries in nursing homes. As food, it also duplicates payments already being made to the nursing home. In addition, reimbursement for nutrients exceeds the purchase price commonly available to nursing homes by over 40 percent, because separate payment does not take advantage of nursing homes' purchasing power.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Medicare	$174	$174	$174	$174	$174

(Proposal may result in slight cost shifting to Medicare Part A and Medicaid.)

Status:

The HCFA concurred with our recommendation. Included in the Balanced Budget Act of 1997 is a provision for a prospective payment system for Part A covered skilled nursing facility stays which will effectively eliminate separate payment for enteral nutrients. Payments made for non-Part A covered stays will continue to be allowable but must be billed by the nursing facility.

Report:

OEI-06-92-00861 (Final report, Mar. 1996)

MINIMIZE PAYMENTS FOR PORTABLE IMAGING SERVICES

Current Law:

Nursing homes arrange for ancillary services (such as x-rays) for patients who require them. In some instances, firms known as portable imaging suppliers provide x-ray and electrocardiogram services in nursing homes. Imaging services consist of several components--technical, professional, transportation, and setup--depending on the type of service and where and by whom it is rendered.

Proposal:

The HCFA should seek legislation, as appropriate, to ensure that historically inflated payments are not built into the prospective payment system that will reimburse care provided under a Part A covered stay. Additionally, under Part B, payments for transportation should be limited to the national median (and prorated when multiple patients are seen), and payments for x-ray setup should be eliminated. The HCFA also should enforce the requirement that physicians justify the need for portable services.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

Medicare pays more than twice as much for imaging services when they are billed under arrangement than when payment is limited to the fee schedule. Also, the amounts Medicare carriers allow for transportation of portable x-ray equipment vary widely, and some are excessive. Additionally, there is no statutory requirement for HCFA to allow setup charges for portable x-rays, and these appear unjustified. Finally, our review of the medical records of nursing home residents receiving portable x-ray services showed that 31 percent of the records lacked a physician order for the portable service and that 53 percent lacked documentation that the patient was not ambulatory.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Inflated Part A payments	$ 28.3	$ 30.0	$ 31.9	$ 33.9	$ 36.0
Transport and x-ray setup	37.5	38.6	39.9	41.4	43.0
Justification for portable service	63.7	68.6	73.9	79.6	85.8
Total	$129.5	$137.2	$145.7	$154.9	$164.8

Status:

The HCFA did not agree with our recommendations.

Report:

OEI-09-95-00090 (Draft report, Feb. 1997)
OEI-09-95-00091 (Draft report, Feb. 1997)

CHANGE THE WAY MEDICARE PAYS FOR CLINICAL LABORATORY TESTS

Current Law:

The amount the Medicare program pays for most clinical lab tests is based on fee schedules. These fee schedules, effective July 1, 1984, were established by each carrier at 60 percent of the Medicare prevailing rate (the rate most frequently used by all suppliers). The Congress took action in the Omnibus Budget Reconciliation Act of 1990 to pay comparable prices by limiting the annual fee schedule increase to 2 percent for 1991, 1992, and 1993 and by reducing the national cap to 88 percent of the median of all fee schedules. The Omnibus Budget Reconciliation Act of 1993 further reduced the national Medicare fee cap to 80 percent of the median of carrier prices in 1995 and to 76 percent in 1996. The law also called for no cost-of-living increases for 1994 and 1995.

Proposal:

The HCFA should (1) develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests and (2) study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

The Omnibus Budget Reconciliation Act of 1993, if fully implemented, should reduce the higher profit rates from Medicare billings. However, although prices on individual tests are being reduced by legislation, panels are still generally being billed as individual tests to Medicare. Medicare policies are not sufficient to control the billing of profile tests because there is no requirement that the tests ordered as a panel by the physician be billed only as a panel. The HCFA's guidelines do not address the problem of panels as a marketing mechanism of the laboratory industry or the problem of industry billing for the contents of the panels individually. In our opinion, these conditions have contributed to the significant increase in the use of laboratory services.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Panels	TBD	TBD	TBD	TBD	TBD
Co-payment	$1,130	$1,240	$1,370	$1,520	$1,690

Status:

The HCFA concurred with our first recommendation but not our second. The agency recently added that it is encouraging the individual ordering of tests to help control utilization and is therefore discouraging the creation of laboratory or physician specific customized panels.

The Balanced Budget Act of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002.

Report:

A-09-89-00031 (Final report, Jan. 1990)
A-09-93-00056 (Follow-up report, Jan. 1996)

REQUIRE PHYSICIAN EXAMINATION BEFORE ORDERING HOME HEALTH SERVICES

Current Law:

Section 1861 of Title XVIII of the Social Security Act authorizes Medicare Part A payment for home health care services. Under the home health benefit, providers are reimbursed for the cost of each visit up to limits established by the Department.

Proposal:

The HCFA should revise Medicare regulations to require the physician to examine the patient before ordering home health services. As discussed in the "Status" section, other OIG recommendations to correct abusive and wasteful practices are being addressed.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

Audits and investigations have identified medically unnecessary care and inappropriate fraudulent billing by specific home health agencies. Other OIG studies describe extreme variations and broad patterns of billing by these agencies, which raise questions about the appropriateness of some billings. We therefore believe it is necessary to place systematic controls on the home health benefit to prevent abuse.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

Although the Congress and the Administration included provisions to restructure home health benefits in the Balanced Budget Act of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification.

Report:

A-04-95-01103 (Final report, Mar. 1996)
OEI-04-93-00262 (Final report, Sept. 1995)
OEI-12-94-00180 (Final report, May 1995)
A-04-94-02087 (Final report, June 1995)
A-04-96-02121 (Final report, July 1997)
A-04-95-01104 (Final report, June 1996)
OEI-04-93-00260 (Final report, July 1995)
OEI-02-94-00170 (Final report, June 1995)
A-04-94-02078 (Final report, Nov. 1994)

ENSURE VALIDITY OF MEDICARE HOSPICE ENROLLMENTS

Current Law:

Hospice care is a treatment approach which recognizes that the impending death of an individual warrants a change in focus from curative to palliative care (such as pain control and symptom management). To qualify for Medicare hospice benefits, which began in 1983, a patient must be entitled to Medicare Part A and be certified as terminally ill, which is defined as having a life expectancy of 6 months or less if the illness runs its normal course.

Proposal:

The HCFA should strengthen its controls over the hospice program, such as by reinforcing the 6-month terminal prognosis requirement; holding hospice physicians more accountable for certifications of terminal prognosis; strengthening claims processing controls; and prohibiting hospices from paying nursing facilities more for "room and board" than the hospices receive from State Medicaid agencies on behalf of dually eligible beneficiaries. The HCFA should also seek legislation to change the payment methodology for dually eligible nursing facility residents; to restructure the use of benefit periods; and to establish a more meaningful cap on hospice payments.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Our audits of 12 large hospices identified a substantial number of ineligible enrollments. Working with OIG, physicians from Medicare peer review organizations reviewed the medical files of 2,109 long-term beneficiaries in hospice care over 210 days and concluded that 1,373 beneficiaries were ineligible because they were not terminally ill. Also, analysis of the HCFA data base for hospice beneficiaries showed evidence of many long-term beneficiaries in other hospices across the country.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The Balanced Budget Act of 1997 modified the hospice benefit but did not address the above recommendations. The HCFA generally concurred with our recommendations and plans to develop a corrective action plan.

Report:

A-05-96-00023 (Final report, Nov. 1997)

REDUCE EXCESSIVE PAYMENTS FOR HOSPICE PATIENTS IN NURSING HOMES

Current Law:

Hospice care is a treatment approach which recognizes that the impending death of an individual warrants a change in focus from curative to palliative care. The Medicare hospice benefit program began in 1983 and was expanded in 1986 to cover individuals residing in nursing facilities. To qualify, a patient must be certified as terminally ill with a life expectancy of 6 months or less if the illness runs its normal course.

Proposal:

The HCFA should modify Medicare or Medicaid payments for hospice patients living in nursing homes.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

In view of the lower frequency of services, the overlap of services, and the questionable enrollment in hospices by nursing home patients, current payment levels for hospice care in nursing homes may be excessive.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA concurred with our recommendation. While the Balanced Budget Act of 1997 made a number of reforms to the hospice benefit, we believe additional corrective action is needed.

Report:

OEI-05-95-00250 (Final report, Sept. 1997)
OEI-05-95-00251 (Final report, Nov. 1997)

REVISE MEDICARE PRESCRIPTION DRUG PAYMENT METHODS

Current Law:

Medicare Part B covers prescription drugs for certain medical disorders, such as end stage renal disease and cancer, and when necessary for the effective use of durable medical equipment. Reimbursement is based on the lower of an estimated acquisition cost or a national average wholesale price (AWP). Payment for drugs under the Medicaid program varies among the States but generally includes use of a discounted acquisition cost, as well as a federally mandated manufacturers' rebate program.

Proposal:

The HCFA should reexamine its Medicare drug reimbursement methodologies with a goal of further reducing payments as appropriate.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

Several OIG studies have indicated that Medicare pays more than other payers for prescription drugs. For example, for three nebulizer drugs in 1994, Medicare and its recipients could have saved substantial amounts by using a discounted AWP reimbursement formula similar to that used by many Medicaid States. Another review of 17 high-volume prescription drugs in the Medicare program in 1994 showed the possibility of substantial savings based on a manufacturer rebate similar to that obtained by the Medicaid program. A more recent review found that manufacturers' published AWP considerably overstates the actual wholesale cost. For 22 drugs with high Medicare allowance amounts, Medicare could have saved $447 million in 1996 by using actual wholesale prices rather than the manufacturers' published AWP. Savings for all Medicare drugs could have been as much as $667 million in 1996.

Savings (in millions):

The savings will depend on the percentage by which the AWP is discounted for Medicare payments. The Balanced Budget Act of 1997 reduced Medicare payments to 95 percent of the AWP. The following estimates, based on a Congressional Budget Office estimate of those savings, show the effects of additional 5 and 10 percent reductions.

	FY 1	FY 2	FY 3	FY 4	FY 5
90% of AWP	$ 80	$110	$110	$40	$30
85% of AWP	160	220	220	80	60

Status:

The HCFA concurred with our recommendation. As noted above, the Balanced Budget Act of 1997 limited Medicare payments for drugs to 95 percent of the AWP.

Report:

OEI-03-94-00390 (Final report, Mar. 1996)
OEI-03-95-00420 (Final report, May 1996)
OEI-03-97-00290 (Final report, July 1997)

ESTABLISH FEE SCHEDULE FOR MEDICARE AMBULANCE PAYMENTS

Current Law:

Medicare pays for medically necessary ambulance services when the use of other methods of transportation would endanger the patient's health. Two levels of service, advanced and basic life support, are covered by Medicare. Reimbursement is based on the type of vehicle and personnel used (advanced or basic life support) and the service status (emergency or nonemergency).

Proposal:

The HCFA should establish new guidelines for ambulance payments:

- Work with the ambulance industry to develop clearer guidelines on what is and is not included in the base rate and what mileage is intended to cover.
- Eliminate separate payments for oxygen, supplies, injectables, and other services, such as electrocardiograms. These items should be included in the base rate.
- Limit the number of procedure codes available to ambulance suppliers for billing.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

Medicare payments for ambulance services appear to lack common sense and are vulnerable to fraud and abuse. For example, in 26 States, Medicare pays more for routine, nonemergency basic life support than it does for advanced life support emergency transportation.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$242	$242	$242	$242	$242

Status:

While the Balanced Budget Act of 1997 mandated the establishment of a fee schedule for Medicare ambulance transportation, we believe that additional savings beyond those contemplated in legislation are possible. We are awaiting HCFA's comments.

Report:

OEI-05-95-00300 (Final report, Nov. 1997)

ALLOW PAYMENT FOR NONEMERGENCY ADVANCED LIFE SUPPORT AMBULANCE SERVICES ONLY WHEN MEDICALLY NECESSARY

Current Law:

The Social Security Act, section 1861(s)(7), provides for coverage of ambulance service when medically necessary. The limitations for this coverage, as specified in 42 CFR 410.40, include the requirement that the services be medically necessary, specifically that other means of transportation would endanger the beneficiary's health. However, because HCFA does not make a coverage distinction between advanced life support and basic life support services, payments are based on the type of transportation furnished and not the level of service required by the beneficiary. Effective March 1, 1982, HCFA allowed separate reimbursement rates for advanced and basic life support ambulances.

Proposal:

The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support services only when that level of service is medically necessary, instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary, and closely monitor carrier compliance.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

From Calendar Years (CY) 1986 to 1989, the number of trips by Medicare beneficiaries in advanced life support ambulances increased by 131 percent, while the number of trips in basic life support ambulances increased by only 14 percent. Of a sample of 400 claims in CY 1989, 18 percent were for services not medically necessary at the advanced level and where basic life support services were available in the same city or town.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47	$47	$47	$47	$47

Status:

The HCFA issued a proposed regulation in June 1997 that would shift the policy focus away from the type of vehicle used and toward the medical condition of the beneficiary.

Report:

A-01-91-00513 (Final report, Oct. 1992)
A-01-94-00528 (Final report, June 1995)

PROVIDE EXPLICIT GUIDELINES ON ALLOWABILITY OF INSTITUTIONAL GENERAL AND ADMINISTRATIVE AND FRINGE BENEFIT COSTS

Current Law:

The HCFA guidelines--Provider Reimbursement Manual, section 2100--establish the general principle that payments to a provider must be covered under Medicare. Sections 2102.1, 2102.2, and 2103 of the manual expand this principle by explaining factors that affect the allowability of costs, such as the reasonableness of costs, their relationship to patient care, and the prudent buyer concept.

Proposal:

The HCFA should revise the Provider Reimbursement Manual to provide explicit guidelines on the allowability of certain general and administrative and fringe benefit costs.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

We reviewed general and administrative and fringe benefit costs at 19 selected hospitals and 2 home offices nationwide in response to a request from the Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce. For 16 of the 19 hospitals reviewed, Medicare participated in approximately $50.7 million of costs that were unallowable, unreasonable, or not allocable to the Medicare program. Although Medicare's share amounted to approximately $2.1 million, the bulk of the costs were passed on to other health care consumers. Also, $3.5 million of costs are "costs for concern" because of their tenuous relationship to patient care. We believe that many of the unallowable costs resulted from the providers' lack of adequate internal controls. However, other unallowable costs, as well as the "costs for concern," appear to have resulted from different interpretations of the guidelines in HCFA's Provider Reimbursement Manual, which is the principal guideline used by providers to charge costs to the Medicare program.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA has published changes to the Provider Reimbursement Manual to clarify the allowability of several of the cost categories identified in our report. In addition, the Balanced Budget Act of 1997 prohibits payments for such items as entertainment, gifts, and donations. The HCFA should clarify the remaining cost categories noted in our report.

Report:

A-03-92-00017 (Final report, Aug. 1994)

DISCONTINUE USE OF A SEPARATE CARRIER TO PROCESS MEDICARE CLAIMS FOR RAILROAD RETIREMENT BENEFICIARIES

Current Law:

From the inception of the Medicare supplementary medical insurance program (Part B), claims for Railroad Retirement beneficiaries have been processed by a single carrier. This carrier, The Travelers Insurance Company, has a contract with the Railroad Retirement Board to process Medicare Part B claims for Railroad Retirement beneficiaries. All other Medicare carriers contract with HCFA to process claims. The authority for this unique contracting arrangement is section 1842(g) of the Social Security Act, as amended.

Proposal:

The HCFA should discontinue the use of a separate carrier to process Medicare claims for Railroad Retirement beneficiaries.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Since 1979, the General Accounting Office, the Grace Commission, and HCFA have recommended that Railroad Retirement beneficiaries be placed under the HCFA carrier system. In following up on these recommendations, we found that cost savings of $9.1 million could be achieved by implementing the proposal. In addition, provider billings would be simplified since the service providers would no longer need to separate and submit Railroad Retirement claims for payment to Travelers and other Medicare claims to a different carrier. A further benefit is that beneficiaries would be assured that their claims would be processed timely and not routed to the wrong carrier for payment, as has sometimes happened in the past.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$9.1	$9.1	$9.1	$9.1	$9.1

Status:

While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.

Report:

A-14-90-02528 (Final report, Dec. 1990)

RAISE THE MEDICARE ENTITLEMENT AGE TO 67

Current Law:

The Social Security Act and related laws established a number of Federal programs, including Social Security Retirement Insurance benefits and the Medicare program. Historically, Social Security and Medicare have been closely linked. Both established age 65 as their entitlement age. The Social Security Amendments of 1983 increased the age of entitlement for Social Security unreduced benefits from age 65 to age 67 over the transition period 2003 to 2027. This was done as one of several methods to strengthen the solvency of the Social Security Trust Fund. However, the age of entitlement for Medicare has remained unchanged.

Proposal:

The HCFA should gradually increase the Medicare entitlement age to 67, following the same schedule for the increase in the age of entitlement to unreduced Social Security benefits.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

If the Medicare entitlement age were gradually raised to age 67 following the same schedule as the Social Security program, the Medicare Hospital Insurance Trust Fund would save three quarters of a trillion dollars over a 30-year period beginning in the year 2003. The Medicare Supplementary Medical Insurance program would also save significant amounts, and since the impact of raising the entitlement age on future Medicare beneficiaries is not known, potential negative consequences could be reduced by providing substantial advance notice of the change. The proposal could help alleviate the Federal deficit and deal with the projected solvency of the trust fund.

Savings:

Potential savings would amount to approximately $60 billion per year in the years immediately after the entitlement age reaches 67 in 2027. In today's terms, this amounts to between $4.7 and $14.6 billion per year, depending on the measure used. Savings would first be realized in 2003 and would increase each year until 2027.

Status:

The HCFA currently has no plans to pursue this change. Although a bill to raise the entitlement age to 67 was introduced in the 105th Congress, it was not enacted.

Report:

OEI-07-91-01600 (Final report, Nov. 1992)

SUBJECT FUNDS PLACED IN FLEXIBLE BENEFIT PLANS TO HOSPITAL INSURANCE TAX

Current Law:

Flexible benefit plans are employer-employee arrangements in which the employee elects a reduced salary and receives payment in the form of fringe benefits. The fringe benefits selected instead of salary are exempt from Medicare, Social Security, and Federal income taxes. These plans are authorized by section 125 of the Internal Revenue Code.

Proposal:

The value of the amounts placed in flexible benefit plans should be included in the definition of wages for the Hospital Insurance portion of the Federal Insurance Contributions Act tax.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Flexible benefit plans deprive the financially unstable Medicare Hospital Insurance trust fund of needed revenue. Also, the tax break provided by these plans is discriminatory as it is not available to all workers and may indirectly contribute to the rapid rise of health care costs. An exemption from Medicare taxes seems particularly inappropriate because the costs of Medicare benefits provided to individuals already far exceed taxes paid to the Medicare trust fund.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$291	$354	$421	$489	$555

Status:

The HCFA agreed with our recommendation and has submitted a legislative proposal to subject flexible benefit plans to the Hospital Insurance tax. However, the proposal was not included in the President's budget.

Report:

A-05-93-00066 (Final report, Aug. 1994)

IMPROVE MEDICARE SECONDARY PAYER SAFEGUARDS

Current Law:

Medicare is the secondary payer (MSP) to certain group health plans in instances where medical services were rendered to Medicare-entitled employees or to the Medicare-entitled spouses and other family members of employees. Medicare is also the secondary payer in situations involving coverage under Worker's Compensation; black lung benefits; automobile and nonautomobile, no fault, or liability insurance; and Department of Veterans Affairs programs. The HCFA provides administrative funds to Medicare contractors to monitor and collect incorrect primary benefits paid on behalf of Medicare beneficiaries.

Proposal:

The HCFA should (1) ensure that contractor resources are sufficient and instruct contractors to recover improper primary payments from insurance companies other than the Blue Cross and Blue Shield insurance companies,
(2) implement financial management systems to ensure all overpayments (receivables) are accurately recorded,
(3) develop detailed procedures to properly handle employers that refuse to provide other health insurance coverage information, and (4) resubmit the justification of a legislative proposal that would require insurance companies, underwriters, and third-party administrators to periodically submit private insurance coverage data directly to HCFA.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Although agreement was reached to relieve all Blue Cross and Blue Shield plans of past due MSP overpayments and although there is a 3-year future plan to identify MSP situations, it applies only to the Blue Cross and Blue Shield plans and not to other insurance companies. Additional measures are still needed to collect accurate and timely information on other primary payers. This will help to reduce future Medicare overpayments that result from unidentified MSP cases and improve the recovery process for overpayments.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA is pursuing the recommended administrative actions through improved processes to identify and recover overpayments related to MSP, as well as improved information systems to guard against making improper Medicare payments where the Blue Cross and Blue Shield plans are primary payers. However, safeguards are still needed to guard against improper payments where insurance companies other than the Blues are primary payers.

Report:

A-09-89-00100 (Final management advisory report, Mar. 1990)
OEI-07-90-00760 (Final report, Aug. 1991)
OEI-03-90-00763 (Management advisory report, Nov. 1991)
A-09-91-00103 (Final report, Aug. 1992)
A-14-94-00391 (Final report, Dec. 1993)
A-14-94-00392 (Final report, Mar. 1994)

EXPAND MEDICARE SECONDARY PAYER PROVISIONS FOR END STAGE RENAL DISEASE BENEFITS

Current Law:

The Omnibus Budget Reconciliation Act of 1981 changed the status of Medicare from primary to secondary payer for beneficiaries with end stage renal disease (ESRD) for the first 12 months of health benefits. Effective February 1, 1990, Medicare became secondary payer for the first 18 months of Medicare entitlement. After October 1, 1998, Medicare again became the secondary payer for the first 12 months.

Proposal:

The Medicare secondary payer (MSP) provision should be extended to include ESRD beneficiaries without a time limitation.

Legislative	Regulatory	Other Administrative
☑	☐	☐

Reason for Action:

The proposed change for ESRD beneficiaries would make MSP provisions consistent with legislation passed by the Congress for aged and disabled beneficiaries, which does not restrict the period of time that Medicare is the secondary payer.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA was concerned that an indefinite secondary payer provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The HCFA favored indefinitely extending the MSP provision for all other services and included this proposal in an earlier budget submission. Although the Balanced Budget Act of 1997 extends MSP policies for individuals with ESRD to 30 months, we continue to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.

Report:

A-10-86-62016 (Final report, Dec. 1987)

MODIFY FORMULA FOR THE MEDICAID PROGRAM

Current Law:

The Federal Medical Assistance Percentage prescribed in the Social Security Act determines the Federal share of costs for the Medicaid and various other programs.

Proposal:

The HCFA should consult with the Congress on modifications to the Federal Medical Assistance Percentage formula which would result in distributions of Federal funds that more closely reflect per-capita-income relationships.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The Federal Medical Assistance Percentage formula does not fully reflect the congressional objective of distributing Federal funds according to a State's ability to share in program costs, as measured by State per capita income. Two provisions result in higher income States' receiving significant additional Federal funds beyond amounts the formula would provide if it were based solely on per-capita-income relationships. Changes to these provisions, namely (1) eliminating the program growth incentive of the formula and (2) lowering the current minimum floor to 45 percent (from 50 percent), would result in distributions of Federal funds that more closely reflect per-capita-income relationships. If the formula were changed, higher income States (such as New York and California) would receive a reduced Federal share in program expenditures, while lower income States (such as Mississippi and Arkansas) would receive a greater Federal share. Higher income States could offset the Federal share reduction by reducing their comparatively greater program benefits. However, if a cost-of-living factor were added to the formula, it would help ensure that any reductions in Federal sharing would be more equitable.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$4,100	$4,100	$4,100	$4,100	$4,100

Status:

The HCFA did not agree with our recommendation, and no legislative proposal was included in the President's current budget.

Report:

A-06-89-00041 (Final report, Aug. 1991)

PROMOTE MEDICAID COST SHARING

Current Law:

Section 1902(a)(14) of the Social Security Act provides that Medicaid may impose "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges." Children, health maintenance organization (HMO) enrollees, pregnancy services, emergency services, and hospice services provided to residents of nursing facilities or medical institutions are exempt from cost sharing.

Proposal:

The HCFA should promote the development of effective cost sharing programs by:

- Allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts,
- Recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services and allowing for higher recipient cost sharing amounts, and/or
- Promoting the use of cost sharing in States that do not currently have programs.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Cost sharing programs, which save money, are used by 27 States in their Medicaid programs. States without cost sharing could save between $167 and $335 million annually (of which the Federal share would be $99 to $198 million) by applying cost sharing to just four services: inpatient hospital, outpatient hospital, physician visits, and prescription drugs. States with cost sharing do not report significant impacts on utilization of services or access to care and have not experienced excessive administrative, recipient, or provider burdens. Federal requirements may hinder States from designing even more effective cost sharing programs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$121.7	$135.9	$151.8	$169.6	$189.5

Status:

The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs and, if a State asks for help, will assist by soliciting information from States that currently impose cost sharing and will share those experiences.

Report:

OEI-03-91-01800 (Final report, July 1993)

SUPPORT MEDICAID PAYMENTS OF PREMIUMS FOR EMPLOYER GROUP HEALTH INSURANCE

Current Law:

Effective January 1, 1991, section 1906 of the Social Security Act mandated that State Medicaid agencies, when cost effective, pay premiums for employer group health plan insurance for Medicaid-eligible individuals.

Proposal:

The HCFA should propose legislation that allows States to pay employer group health plan deductibles and coinsurance using Medicaid fee schedules rather than group health plan fee schedules.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Most States have not purchased employer group health plan insurance for Medicaid-eligible individuals, and compliance with current legislation could reduce potential savings resulting from such insurance.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$34.7	$37.6	$40.8	$44.3	$48.1

Status:

The HCFA deferred commenting on our recommendation because of legislative proposals being considered at that time.

Report:

OEI-04-91-01050 (Final report, May 1994)

CLOSE LOOPHOLES THAT SHELTER THIRD PARTY LIABILITY SETTLEMENTS AND AWARDS

Current Law:

Some Medicaid recipients who receive settlements and awards from liable third parties as a result of accidents are able to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. With these trusts, they are also able to prevent Medicaid from being repaid for medical services related to injuries sustained in the accidents.

Proposal:

The HCFA should develop (1) legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 and (2) guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Our national survey of the 51 Medicaid agencies disclosed that in 36 agencies, Medicaid and Supplemental Security Income recipients used trusts to shelter assets. Although we were unable to determine the financial impact of these trust funds on Medicaid nationally, we concluded that the impact on Medicaid from 25 such trusts in California was significant.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$3	$3	$3	$3	$3

Status:

The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g., health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements. In June 1996, HCFA issued guidelines which set forth advice on ways in which States can better recover Medicaid expenditures from established third party settlements, especially for the disabled population.

Report:

A-09-93-00033 (Final report, Oct. 1994)

IMPLEMENT AN INDEXED BEST PRICE CALCULATION IN THE MEDICAID DRUG REBATE PROGRAM

Current Law:

The Omnibus Budget Reconciliation Act of 1990 authorized States to collect rebates from drug manufacturers for drug purchases made under the Medicaid program. Rebates are calculated using average manufacturer price (AMP), the manufacturer's best price, and other factors. To discourage drug manufacturers from raising AMP amounts, the basic rebate amount is increased by the amount AMP increases over and above the consumer price index for all urban consumers. However, no similar indexing of best price is made, even though best price is part of the basic rebate calculation for brand name drugs.

Proposal:

The best price calculation in the Medicaid drug rebate program should be indexed.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Drug manufacturers have consistently increased best prices in excess of the consumer price index for all urban consumers since the inception of the Medicaid drug rebate program. To determine the potential effect that increases in best price (beyond the rate of inflation) had on rebates, we calculated the difference in rebates that would have resulted from using an indexed best price. We estimate that drug rebates would have increased by about $123 million for the 406 drug products included in our review.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$123	$123	$123	$123	$123

Status:

We are continuing to monitor the Medicaid drug rebate program; audits will continue to focus on enhancing the collection of rebates and providing potential savings to the rebate program.

Report:

A-06-94-00039 (Final report, Oct. 1995)

REDUCE NONEMERGENCY USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS

Current Law:

States attempting to control nonemergency use of emergency rooms must consider several Federal requirements. Medicaid recipients must have the right to freedom of choice of a health care provider as stated in section 1902 (a)(23) of the Social Security Act. Before recipients are restricted in this choice, a waiver under section 1915(b) must be obtained.

Proposal:

The HCFA should encourage States to develop initiatives for reviewing and reducing nonemergency use of emergency rooms by Medicaid recipients and should assist them through data analysis instructions, expedited review of waiver applications for managed care, and dissemination of effective emergency room control practices.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Heavy nonemergency use of emergency rooms by Medicaid recipients has been a continuing problem, and substantial Medicaid savings could be realized by redirecting nonemergency visits to more appropriate and less costly care sites. States have developed controls to improve access to, and continuity of, care as well as to reduce costs of determining which managed care/pre-paid programs are the most successful.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$80.5	$103.8	$133.9	$172.7	$222.8

Status:

While HCFA was concerned that it may not have sufficient resources to encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms or to disseminate annual reports on effective practices, it will expedite the review of State applications for waivers to implement their efforts to control emergency rooms.

Report:

OEI-06-90-00180 (Final report, Mar. 1992)

INSTALL EDITS TO PRECLUDE IMPROPER MEDICAID REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES

Current Law:

Clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. Medicaid reimbursement for these tests may not exceed the amount that Medicare recognizes, and each Medicare carrier in a State is to provide its fee schedule to the State agency. For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002 - 89399 of the Current Procedural Terminology Manual. Effective for services rendered on or after July 1, 1984, Federal matching funds are not available for any amount over the amount recognized by Medicare for such tests.

Proposal:

The State agencies should (1) install edits to detect and prevent payments that exceed the Medicare limits and billings that contain duplicative tests, (2) recover overpayments for clinical laboratory services identified in each of the reviews, and (3) make adjustments for the Federal share of the amounts recovered by the State agencies.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Overall, our reviews disclose that State agencies are reimbursing providers for laboratory services which exceed the Medicare limits or are duplicated for payment purposes. These overpayments are occurring because the State agencies do not have adequate computer edits in place to prevent the payment of unbundled or duplicated claims for chemistry, hematology, or urinalysis tests.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$14	$14	$14	$14	$14

Status:

The HCFA is evaluating our results.

Report:

A-01-95-00005 (Final report, Jan. 1996)
A-01-96-00001 (Final report, Feb. 1996)
A-04-95-01108 (Final report, Dec. 1995)
A-04-95-01109 (Final report, Apr. 1996)
A-04-95-01113 (Final report, Feb. 1996)
A-05-95-00035 (Final report, Feb. 1996)
A-05-96-00019 (Final report, Mar. 1996)
A-06-96-00031 (Final report, Dec. 1995)
A-06-95-00078 (Final report, Nov. 1995)
A-07-95-01139 (Final report, Sept. 1995)
A-07-95-01147 (Final report, Oct. 1995)
A-07-95-01138 (Final report, Mar. 1996)
A-09-95-00072 (Final report, May 1996)
A-10-95-00002 (Final report, Mar. 1996)

CONTROL MEDICAID PAYMENTS TO INSTITUTIONS FOR MENTALLY RETARDED PEOPLE

Current Law:

Federal Medicaid rules for reimbursing States for intermediate care facilities/mentally retarded are not tailored to the operations of these institutions. "Reasonable costs" and "efficiently and economically operated facility" are not defined in regulations. Each State has considerable discretion in defining these terms and in setting payment methodology.

Proposal:

The HCFA should reduce excessive spending of Medicaid funds for intermediate care facilities/mentally retarded by one or more of the following:

- Take administrative action to control reimbursement by encouraging States to adopt controls.
- Seek legislation to control reimbursement, such as through mandatory cost controls, Federal per capita limits, flat per capita payments, case-mix reimbursements, or a national ceiling for reimbursements.
- Seek comprehensive legislation to restructure Medicaid reimbursement for both intermediate care facilities/mentally retarded and home and community-based waiver service for developmentally disabled people via global budgeting, block grants, or financial incentive programs.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Medicaid reimbursement rates for large intermediate care facilities/mentally retarded are more than five times greater in some States than in others. The average Medicaid reimbursement in 1991 for large facilities ranged among States from $27,000 to $158,000 per resident. This variation was unrelated to the patients' severity of illness, quality of service, facility characteristics, or resident demographics. A lack of effective controls results in excessive spending.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$683	$683	$683	$683	$683

Status:

The HCFA sent copies of our report to State Medicaid Directors but did not concur with our recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The Balanced Budget Act of 1997 requires the Secretary to conduct a study on the effect of the States' rate-setting methods on access to, and quality of, services provided to beneficiaries.

Report:

OEI-09-91-01010 (Final report, June 1993)

PUBLIC HEALTH SERVICE AGENCIES

Public Health Service Agencies

Overview

The activities conducted and supported by the Public Health Service (PHS) operating divisions represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people.

These independent operating divisions include the National Institutes of Health (NIH), to advance our knowledge through research; the Food and Drug Administration (FDA), to ensure the safety and efficacy of marketed drugs, biological products, and medical devices; the Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; the Health Resources and Services Administration (HRSA), to support the development, distribution, and management of health care personnel, other health resources, and services; the Indian Health Service (IHS), to improve the health status of Native Americans; the Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice and in the organization, financing, and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services.

Significant OIG Activities

The Office of Inspector General (OIG) concentrates on such issues as biomedical research, substance abuse, acquired immune deficiency syndrome, and medical effectiveness. Significant unimplemented monetary recommendations identified by the OIG relate to instituting and collecting user fees for FDA activities and changing Office of Management and Budget Circular A-21 to effect more productive use of Federal research dollars at the Nation's colleges and universities.

INSTITUTE AND COLLECT USER FEES FOR FOOD SAFETY INSPECTIONS

Current Law:

The Food and Drug Administration (FDA) imposes user fees for several activities, including color certification and reconditioning of products. In 1993, the FDA began collecting fees for activities covered by the Prescription Drug User Fee Act. In the absence of specific authorizing legislation, the FDA is precluded by statute from imposing user fees to cover additional functions.

Proposal:

The FDA should extend user fees to various FDA functions, possibly including pre-market review and approvals for devices, inspections of manufacturing facilities, and food processors and establishments.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

User fees, if properly instituted, represent a legitimate method to recover regulatory costs. Such fees would be consistent with fee systems in other Federal regulatory environments, such as the Environmental Protection Agency, the Federal Communications Commission, and the Nuclear Regulatory Commission. In addition, user fees would properly reflect the value of discrete benefits enjoyed by manufacturers from FDA's regulatory activities, such as increased consumer confidence in products and protection from unfair competition.

The imposition of user fees for major FDA regulatory functions not only will shift the economic burden of FDA's functions to users but will have the potential added benefits of increasing revenue for needed expansion of services, improving agency tracking of resources, and increasing agency accountability for the costs of regulation.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$175.9	$185.5	$185.5	$185.5	$185.5

Status:

The total estimated FY 1998 collections for all user fees are $112.7 million ($7.5 million from certification, $91.2 million from Prescription Drug User Fee activities, and $14 million from the Mammography Quality Standards Act). The President's FY 1998 budget request included a provision to assess additional user fees that would mostly replace existing base appropriations for foods, human drugs, biologics, animal drugs, and devices. However, FDA's FY 1998 appropriation did not include this provision. New legislation is required to authorize additional user fees.

Report:

OEI-12-90-02020 (Final report, July 1990)
OEI-05-90-01070 (Final report, Aug. 1991)

CAP MEDICAL MALPRACTICE COVERAGE TO COMMUNITY AND MIGRANT HEALTH CENTERS

Current Law:

The Federal Tort Claims Act provides unlimited medical malpractice coverage to Community and Migrant Health Centers. Under the act, the Government consents to be sued for claims resulting from any personal injury caused by the negligence of employees who were acting within the scope of their employment. The Federally Supported Health Centers Assistance Act of 1992, Public Law 102-501, extended this coverage to Community and Migrant Health Centers' medical personnel for a 3-year demonstration period beginning January 1, 1993. The 1992 act has since been extended indefinitely.

Proposal:

The Health Resources and Services Administration (HRSA) should consider seeking a legislative change that will limit to $1 million malpractice settlements or judgments involving Community and Migrant Health Centers.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The U.S. General Accounting Office (GAO) reported in 1993 that malpractice insurance with unlimited dollar coverage, such as the Federal Tort Claims Act currently provides, will generally cost about 50 percent more than coverage limited to $1 million per claim. The GAO also reported that about 57 percent of the policies Community and Migrant Health Centers purchased from private insurers during Calendar Year 1991 provided coverage up to $1 million per claim. Our actuarial consultant advised us that for this same period, the average limit purchased at that time by the centers was $850,000. The consultant estimated that the Federal Government would incur $30.6 million more over a 3-year period to provide unlimited dollar coverage, compared with providing coverage with a limit of $1 million per claim.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$10	$10	$10	$10	$10

Status:

After conferring with the Department of Justice, HHS has decided not to seek a legislative change at this time.

Report:

A-04-95-05018 (Final report, Mar. 1996)

IMPROVE INDIAN HEALTH SERVICE BILLINGS AND COLLECTIONS FROM PRIVATE HEALTH INSURANCE COMPANIES

Current Law:

The Indian Health Service (IHS) funds health care to American Indians and Alaska Natives through appropriations by the Congress and collections from third party resources. Public Law 100-713, the Indian Health Care Amendments of 1988, authorizes the IHS to bill third parties, including private insurance companies, for both inpatient and outpatient services. According to IHS, reimbursements received from private insurance companies for patients in IHS-operated facilities are used to establish IHS business offices and purchase medical supplies and equipment.

Proposal:

The IHS should establish the necessary internal controls, assign adequate resources to its business offices, and provide additional training to business office staff to ensure that underbillings of approximately $7 million per quarter are properly filed and collected.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

The IHS had not established the controls necessary to ensure that the amounts billed to private insurance companies were accurate and that all covered services were billed. As a result, for the 3-month period we tested, IHS underbilled private insurers by approximately $7 million.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$28	$28	$28	$28	$28

Status:

The IHS fully concurred with our recommendations and is in the process of (1) implementing an automated system to achieve the necessary internal controls, (2) allocating resources to improve methods for billings and collections, (3) meeting the training needs of business office staff, (4) implementing fee schedules on a timely basis, (5) ensuring adequate accounting and medical records are maintained for each patient, (6) providing adequate resources to carry out claims follow-up, and (7) improving policies and procedures for follow-up of unpaid claims.

Report:

A-06-93-00080 (Final report, June 1995)

PROPOSE CHANGES TO OFFICE OF MANAGEMENT AND BUDGET CIRCULAR A-21 REGARDING RECHARGE CENTERS

Current Law:

The Office of Management and Budget (OMB) Circular A-21, "Cost Principles for Educational Institutions," requires that billing rates for specialized service funds (recharge centers) be based on actual costs, designed to recover the aggregate cost of goods or services, and reviewed periodically.

Proposal:

The Assistant Secretary for Management and Budget should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for (1) establishing, monitoring, and adjusting billing rates to eliminate accumulated surpluses and deficits, (2) preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates, (3) ensuring that Federal projects are billed equitably, and (4) excluding recharge costs from the recalculation of facilities and administrative cost rates.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

At 15 universities, 21 of the 87 recharge centers (1) accumulated surplus fund balances and deficits which were not used in the computation of subsequent billing rates, (2) overstated billing rates by transferring funds from center accounts or including unallowable costs in rate calculations, (3) billed users inequitably, and (4) used recharge center fund balances (surpluses or deficits) inappropriately to calculate facilities and administrative cost rates. These practices resulted in overcharges to the Federal Government of $1.9 million during fiscal years 1995 and 1996.

Savings (in millions):

FYs 1 & 2	FY 3	FY 4	FY 5
$1.9	*	*	*

** Recurring savings would result with the circular change.*

Status:

The Deputy Assistant Secretary for Grants and Acquisition Management concurred with our recommendations. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions.

Report:

A-09-96-04003 (Final report, Mar. 1997)

LIMIT GRADUATE STUDENT COMPENSATION TO THAT PAID FOR SIMILAR WORK

Current Law:

The OMB Circular A-21, "Cost Principles for Educational Institutions," requires that tuition remission (the forgiveness by the institution of all or a portion of the student's tuition costs) and other forms of compensation charged to federally sponsored research be reasonable.

Proposal:

The Assistant Secretary for Management and Budget should work with OMB to revise Circular A-21 to stipulate a reasonableness standard for graduate student compensation based on assigned responsibilities and not to exceed compensation paid to other individuals of similar experience for similar work.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Although OMB Circular A-21 requires that tuition remission and other forms of compensation charged to federally sponsored research be reasonable, it provides unclear guidance in defining "reasonableness," relying on the concepts of the prudent person and arm's length bargaining. In the absence of a consistent standard, we used the salaries of postdoctoral research assistants and equivalent positions as a "fair and reasonable benchmark" for measuring the reasonableness of compensation packages provided to graduate students at four universities. Based on a statistical sample, three of the four universities audited charged a total of $5.7 million in unreasonable graduate student compensation to federally sponsored research projects.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$5.7	*	*	*	*

** Recurring savings would result with the circular change.*

Status:

The Department endorsed our recommendation, concluding that a prudent person would not provide greater compensation to individuals who are less qualified by education and practical experience than to others performing similar work. Also, NIH issued a notice in its Guide for Grants and Contracts which provides that reasonable compensation for graduate students will not exceed the amount allowable for a first-year postdoctoral level staff member at the same institution performing comparable work.

Report:

A-01-94-04002 (Final report, Oct. 1994)

ADMINISTRATION FOR CHILDREN AND FAMILIES

Administration for Children and Families

Overview

The Administration for Children and Families (ACF) provides Federal direction and funding for State, local, and private organizations as well as for State-administered programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families. It also oversees a variety of programs that provide social services to the Nation's children, youth, and families; persons with developmental disabilities; and Native Americans.

To reduce dependency on welfare programs, the Personal Responsibility and Work Opportunity Act of 1996 eliminated the Aid to Families with Dependent Children, Emergency Assistance, and Job Opportunities and Basic Skills Training programs as of FY 1997 and created the Temporary Assistance for Needy Families (TANF) block grant. The ACF oversees TANF, as well as the Child Support Enforcement program, which provides grants to States to enforce obligations of absent parents and to establish and enforce child support orders, and the Head Start program, which provides comprehensive health, educational, nutritional, social, and other services primarily to economically disadvantaged preschool children and their families. Also, the Foster Care and Adoption Assistance program provides grants to States to assist with the cost of foster care and special needs adoptions, as well as maintenance, administrative, and staff training costs. Other programs include Community Services and the Child Welfare program.

Significant OIG Activities

The Office of Inspector General (OIG) reviews the cost-effectiveness of ACF social services and assistance programs, including determining whether authorized services are provided to recipients at the lowest costs. These reviews have identified opportunities to improve the delivery of program services, such as by requiring States to develop criteria and implement procedures for ensuring that appropriate foster care cases are referred to State child support enforcement agencies and limiting Federal participation in foster care administrative costs.

REFER FOSTER CARE CASES TO CHILD SUPPORT ENFORCEMENT AGENCIES

Current Law:

Section 11 of the 1984 Child Support Amendment Act requires States to secure and enforce child support collections on behalf of children receiving foster care maintenance payments under Title IV-E of the Social Security Act "where appropriate."

Proposal:

As a condition of receiving Federal matching funds for foster care administration under Title IV-E, the ACF should require States to develop criteria and implement procedures for ensuring that foster care agencies refer appropriate cases to State child support agencies. We believe this would increase child support collections on behalf of foster care children, thus offsetting tax dollars spent for their care and maintenance.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Collections are being made on behalf of only 5.9 percent of foster care children in our sample. Few foster care cases are referred to child support agencies for possible collections.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$11	$11	$11	$11	$11

Status:

Over the last several years, ACF has redesigned its program monitoring system for all child welfare services. Also, section 105 of Public Law 105-89, signed November 19, 1997, mandates the use of the Federal Parent Locator Service for Child Welfare Services. The Children's Bureau and the Office of Child Support Enforcement plan to discuss how best to implement these provisions. While ACF is willing to implement a strategy to address our recommendation in light of this new process, it did not agree with our estimate of potential savings.

Report:

OEI-04-91-00530 (Final report, May 1992)

LIMIT FEDERAL PARTICIPATION IN STATES' COSTS FOR ADMINISTERING THE FOSTER CARE PROGRAM

Current Law:

Title IV-E of the Social Security Act makes Federal funding available to States for costs incurred in providing care and maintenance to children eligible for foster care. It also authorizes Federal participation in related administrative and training costs. Placement activities are included in administrative costs.

Proposal:

Limit Federal participation in foster care administrative costs through one of the following actions: (1) limit future increases in administrative costs to no more than 10 percent per year; (2) fund administrative activities via a single block grant with future increases based on the consumer price index; (3) limit administrative costs to a percentage of maintenance payments; or (4) require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. Costs for child placement services should be separated from traditional overhead costs so they can be effectively monitored.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Legislative action is required to control increases in foster care administrative costs. Current "open-ended" legislation has allowed administrative costs to increase from $400 million in FY 1988 to an estimated $1.2 billion in FY 1994- - approximately a 200 percent increase.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$247	$306	$364	$415	$461

Status:

This proposal was not included in the President's current budget. The ACF generally agreed with our recommendation but recently noted that claims for administrative costs have leveled off in the past several years.

Report:

A-07-90-00274 (Final report, Aug. 1990)

IMPROVE STATE OVERSIGHT OF PRIVATE NONPROFIT CHILD PLACING AGENCIES

Current Law:

Foster care maintenance payments, as defined by Title IV-E of the Social Security Act, are intended to cover the cost of food, clothing, shelter, and incidentals required for the child's care. While the act allows States to claim Federal funding for certain administrative costs related to the foster care program, Federal funding is not available for the costs of social services provided to the child, the child's family, or the foster family.

Proposal:

State agencies should improve their oversight activities. Procedures need to be developed to ensure that private nonprofit child placing agencies do not retain a portion of the maintenance payments to meet their operating costs or claim unallowable costs under the Title IV-E program.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Some private nonprofit child placing agencies retained a portion of the foster care payment intended for the foster child's maintenance payments and claimed administrative costs related to social services.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$18.3				

Status:

Final resolution of these audit findings is not yet due; however, ACF is preparing to issue a notice of proposed rulemaking on monitoring, including reviews of Title IV-E, which may address some of these issues.

While the States concurred that the costs claimed were not allowable, they proposed to review certain costs of child placing agencies before making the financial adjustment. The State agencies concurred with our findings and recommendations pertaining to the need to improve their monitoring efforts.

Report:

A-05-96-00055 (Final report, June 1997)
A-09-96-00071 (Final report, Aug. 1997)

OBTAIN GOVERNMENT REIMBURSEMENT FOR HEAD START GRANTEES' UNALLOWABLE CHARGES

Current Law:

Under Title 45 of the Code of Federal Regulations, non-Federal matching and cost sharing contributions must be verifiable and allowable under the applicable cost principles, and the granting agency must preapprove certain changes in the budget and in the grant award proposal. In addition, compensatory time payments are allowed if they follow the grantee's own policy for such payments.

Proposal:

The Federal Government should be reimbursed for ineligible expenditures.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

The grantees claimed unallowable costs, including (1) noncompliance with budget provisions and deviations from grant award proposals ($1,532,072), (2) irregularities in financial accounting ($409,805), (3) noncompliance with preapproval requirements for construction ($351,895), (4) lack of support for labor charges ($237,563), (5) unrecorded liabilities ($216,746), (6) unsupported non-Federal matching funds ($190,840), (7) payments for compensatory time ($30,186), and (8) travel ($4,100).

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$2.973				

Status:

Some grantees did not agree with our findings and recommendations. The ACF is using our findings and recommendations as part of its monitoring activity.

Report:

A-02-95-02005 (Final report, Sept. 1995)
A-04-96-00107 (Final report, May 1997)
A-06-96-00062 (Final report, Aug. 1996)
A-06-96-00063 (Final report, Aug. 1996)
A-08-96-01024 (Final report, Feb. 1997)
A-10-96-00007 (Final report, Mar. 1997)
A-12-96-00017 (Final report, July 1996)

GENERAL DEPARTMENTAL MANAGEMENT

General Departmental Management

Overview

The Office of Inspector General's (OIG) departmental management and Governmentwide oversight role includes reviews of payroll activities, accounting transactions, implementation of the Federal Managers' Financial Integrity Act and the Prompt Pay Act, financial management audits under the Chief Financial Officers Act, grants and contracts, the Department's Working Capital Fund, conflict resolution, and adherence to employee standards of conduct. The OIG also participates in interagency efforts through the President's Council on Integrity and Efficiency and the President's Council on Management Improvement to prevent losses to and abuses of Federal programs.

The OIG has oversight responsibility for these staff division activities at the departmental level. A related major responsibility flows from the Office of Management and Budget's (OMB's) designation of HHS as cognizant agency to audit the majority of the Federal funds awarded to major research schools, 104 State and local government cost allocation plans, and separate indirect cost plans of about 1,000 State agencies and local governments. Also, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG is responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

Significant OIG Activities

The OIG's work in departmental management and Governmentwide oversight focuses principally on financial statement audits, financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance. The OIG also reviews the adequacy of States' systems to control the growth of administrative/indirect costs claimed for Federal financial participation.

SIMPLIFY ADMINISTRATIVE/INDIRECT COST ALLOCATION SYSTEMS

Current Law:

The Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments," establishes requirements that State and local governments must follow in preparing and submitting cost allocation plans for Federal approval. State and local governments must adhere to the plans when claiming administrative/indirect costs for Federal financial participation.

Proposal:

The process for charging administrative/indirect costs to Federal programs should be simplified through reform of the cost allocation plans. We have identified a range of options, some of which require legislative actions, to reform the cost allocation system. These options include (1) use of block grant awards, (2) a flat percentage rate for administrative/indirect costs, and (3) negotiation of a nonadjustable rate for a predetermined number of years.

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

State cost allocation plans annually allocate an estimated $20 billion of administrative/indirect costs to Federal programs. We concluded from a review of 105 statewide cost allocation plans (plans for each of 3 years in 35 States) that the system for allocating costs to Federal programs has degenerated into a highly technical accounting and allocation maze. The Federal, State, and local governmental communities have struggled to work within a burdensome system instituted over 20 years ago that seeks to equitably share administrative/indirect costs. Prior reform efforts concentrated on individual programs and/or cost principles instead of the system or process and thus were not entirely successful.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
*	*	*	*	*

** A report by the National Performance Review, "Creating a Government That Works Better and Costs Less," estimates a 5-year savings of $3.3 billion by reducing intergovernmental administrative costs.*

Status:

The National Performance Review report, which called for reform of the cost allocation process, cited some of our recommendations, and OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.

Report:

A-12-92-00014 (Final report, Sept. 1993)

IMPROVE FUNDING SYSTEM FOR WELFARE ADMINISTRATIVE COSTS

Current Law:

The Federal Government pays for half of the administrative costs for most types of administrative activities in the Medicaid program. States have considerable latitude in defining their administrative costs. Costs need only be considered "reasonable and necessary" as outlined in OMB Circular A-87, "Cost Principles for State and Local Governments." In 1996, the Congress enacted the Temporary Assistance to Needy Families (TANF) block grant which provides grants to States to provide cash to low-income individuals. Since administrative costs are included in this grant, Federal reimbursement for these costs is limited. No such limits apply to the Medicaid program, however.

Proposal:

One of the following options should be used to fund administrative costs in the Medicaid program:

- *Reduction in Medicaid special match rates to 50 percent*.
- *Block grant*. Set a base amount, then provide inflationary increases each year.
- *Standard cost per recipient*. Fund States based on a standard per recipient allocation amount.
- *Cost per recipient cap*. Impose a cap on Federal reimbursement of the cost per recipient.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The current method for reimbursing States for welfare administrative costs is unwieldy, inefficient, and unpredictable. In addition, there is considerable unexplained disparity in administrative costs among States and significant risk of an increase in administrative costs overall. With the new limits imposed on Federal funding of TANF administrative costs, States have incentives to use accounting techniques to shift administrative costs to the Medicaid program in order to receive Federal reimbursement for these costs.

Savings (in millions):

Options	FY 1	FY 2	FY 3	FY 4	FY 5
Reduced special match	$236	$273	$315	$362	$ 415
Block grant	114	376	671	993	1,352
Standard cost per recipient	32	93	135	195	259
Capped cost per recipient	52	58	66	95	84

Status:

Medicaid administrative costs continue to be paid as they have in the past.

Report:

OEI-05-91-01080 (Final report, Jan. 1995)

PROPERLY ALLOCATE TRAINING COSTS UNDER FEDERALLY SUPPORTED PROGRAMS

Current Law:

The Federal Government reimburses States for a portion of the training costs for such programs as the Medicaid, Foster Care, Food Stamp, and Temporary Assistance for Needy Families programs. Under OMB Circular A-87 and various regulations, these costs are required to be allocated to the benefitting State programs and adequately documented.

Proposal:

The States must ensure that training costs are allocated to all benefitting programs, appropriate allocation rates are applied, and unallowable third-party contributions are not claimed.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

The State agencies (1) charged training costs directly to the Federal programs instead of allocating appropriate portions of the cost to the State-funded programs, which also benefit from the training; (2) claimed administrative costs at the enhanced rate of 75 percent rather than the allowable rate of 50 percent; (3) provided insufficient documentation to support costs claimed at the enhanced rate; (4) included duplicate claims; (5) used unallowable third-party contributions to meet matching requirements; (6) claimed costs in excess of the actual costs; and (7) claimed unallowable costs for facilities, equipment, and other miscellaneous items.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$22.2				

Status:

The States generally concurred with the recommendations.

Report:

A-05-96-00043 (Final report, June 1997)
A-07-97-01028 (Final report, Aug. 1997)
A-09-96-00066 (Final report, Sept. 1997)
A-10-96-00004 (Final report, Sept. 1997)

INTERNET ADDRESS

The *1997-98 Red Book* and other OIG materials, including final reports issued and OIG program exclusions, may be accessed on the Internet at the following address:

http://www.hhs.gov/progorg/oig